

S. No. 2
DOM-2-43
Rev. 5-17-39
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22322

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
FILED JUL 28 1945 318

State File No. _____
Registrar's No. 6242

Registration District No. _____ Primary Registration District No. L 1005

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis, (If outside city or town limits, write "RURAL")
(d) Street No. 2902 Dickson (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah Dukes Mitchell

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month July 14 day _____
year 1945 hour 5 minute 30 P. M.

4. Sex Female 5. Color or race negro 6. (a) Single, widowed, married, divorced m 1

21. I hereby certify that I attended the deceased from July 9, 1945
to July 14, 1945
that I last saw h. ST alive on July 14, 1945
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 37 years

Immediate cause of death
Coronary Thrombosis (autopsy)
Cerebral Accident, left

7. Birth date of deceased _____
(Month) (Day) (Year)

Duration
1 hr.
5 days

8. AGE: Years 50 Months - Days - If less than one day _____ hr. _____ min.

Due to _____

9. Birthplace St. Louis mo
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation Homemaker

Other conditions (include pregnancy within 3 months of death) 9/4

11. Industry or business At home

Major findings: Of operations _____
Of autopsy See above

12. Name James Butler

PHYSICIAN
Underline the cause to which death should be charged statistically.

13. Birthplace Ky.
(City, town, or county) (State or foreign country)

14. Maiden name Anna Rankin

15. Birthplace mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Butler
(b) Address 2902 Dickson St.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-20-45
(Month) (Day) (Year)
(c) Place: burial or cremation Father Deakins Cemetery

23. Signature P. F. Murphy (M. D. or other)
Address also w. Butler Date signed 7/17/45

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

20
17
9

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Louis V. Atkins*

Licensed Embalmer No. *2842*

P. O. Address *3644 Finney*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.